

Child Death Review Case Reporting

*County:

*CFR Coordinator:

*Health Department:

Phone:

*Date CFR Coordinator notified of death:

Coroner/Dep. Coroner:

Items marked with an asterisk must be completed. Please fax this form to: Sherry Rock, Child Fatality Review Program Administrator at **502-654-5766** within 24 hours of receiving notice of child's death.

1. *Child's name: First:

Middle:

Last:

2. *Date of death:

3. Date of birth:

4. Age:

5. Race, check all that apply:

White

Black

Asian

Native American

Other, please specify:

6. Hispanic or Latino origin?

Yes

No

7. *Gender:

Male

Female

8. State where child was born:

9. *County of Death:

10. County of Residence:

11. Residence address:

Street:

Apt.:

City:

State:

Zip Code:

12. *Circumstances of Death:

13. Will this case be reviewed by Local CFR Team?

Yes

No

14. How did LHD receive notification of child's death?

Coroner

Parent/Caretaker

Hospital/ER

Law Enforcement

Obituary

Other, please specify:

This Box to be completed by DPH/MCH

Case Number:

_____/_____/_____/_____
State / County Number / Year of Death / Sequence of Review

Notification received on ____/____/____